Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2019	2019_556168_0023	016483-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

Long-Term Care Home/Foyer de soins de longue durée

Anson Place Care Centre
85 Main Street North Hagersville ON N0A 1H0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 30, 31, 2019, November 1, 4 and 5, 2019 and a telephone interview on November 7, 2019.

This inspection was completed related to Complaint Log #016483-19, related to infection prevention and control, medication management, cooling requirements and nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Registered Dietitian (RD), the Food Services Supervisor (FSS), Registered Nurses (RN), Registered Practical Nurses (RPN), Public Health Nurse, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector observed the provision of care and services, reviewed relevant policies and procedures, reviewed logs and clinical health records.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the residents related to nutritional interventions.

A. Resident #007 had a plan of care which identified that they were at risk for heat exhaustion/heat stroke and at nutritional risk.
The focus statement related to heat risk, was in place since April 2019, and included an intervention to push fluids at specified times as directed by the RD related to heat risk.
The focus statement related to nutritional risk did not provide any direction related to "push fluids" and noted that the resident was to be provided foods and fluids as tolerated which was created in August 2019, following an assessment of the resident.
Interview with the DOC, following a review of the clinical record confirmed that the plan of care did not give clear direction to staff who provided care related to nutritional interventions.

B. Resident #010 had a plan of care, with a completed date in August 2019, which identified that they were at heat risk and at nutritional risk.
i. The focus statement related to heat risk, was in place since May 2019, and included an intervention to push fluids at specified times as directed by the RD related to heat risk.
The focus statement related to nutritional risk did not provide any direction related to "push fluids".
ii. The focus statement related to nutritional risk identified that the resident had a goal to drink a specified amount of milliliters (ml) a day based on 75 percent (%) of total fluid target and also noted that their beverage target minimum was a different specified amount of ml a day.
The current plan of care, included a revision to the beverage target minimum fluid goal to be only one amount of ml a day.
iii. The current plan of care, related to nutritional risk included an intervention at meals.
A review of the current Dietary Profile did not include the use of the intervention at meals.
During the observed breakfast meal, the intervention was not provided; however, the resident ate with a specified level of assistance.
Interview with the DOC following a review of the plans of care confirmed that the plan, with a completed date in August 2019, did not provide clear direction to staff providing care regarding fluid interventions.
Interview with the FSS, following a review of the plan of care and profile confirmed that the plan did not give clear direction to staff regarding the intervention and fluid goals. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure procedures included in the required cooling requirements plan for the home were complied with.

In accordance with Ontario Regulation (O. Reg.) 79/10, section (s.) 20(1) the licensee was required to ensure a that written hot weather related illness prevention and management plan, that met the needs of residents, was developed in accordance with evidenced based practices and, if there were none, in accordance with prevailing practices and was implemented when required to address the adverse effects on residents related to heat.

Specifically, the home had a procedure Hot Weather Related Illness, RCS-G-20, reviewed July 2019, which required that "air temperatures and humidity are checked twice daily and humidex levels determined to ensure protocols are put in place as soon

as humidex readings is 29 or higher".
This information was to be recorded on the Monthly Hot Weather Temperature Logs, which required staff to document the date and time of the assessment, the air temperature, percentage of humidity and humidex, level of risk as well as action taken.

Interviews with the DOC and RN #110 and written documentation confirmed that air temperatures and humidity readings were taken, twice a day, in three locations in the long term care home, during the summer months.
A review of the Monthly Hot Weather Temperature Logs, from July and August2019, identified approximately five shifts where the humidex reading was 29 or higher.
On only one of the identified shifts, was the log completed for "action" and included "noticeable discomfort, staff instructed push fluids/popsicles and keep residents in cool areas".
A review of the Monthly Hot Weather Temperature Logs by the Administrator confirmed that although, in their opinion, actions were consistently taken by the home to put the appropriate protocol in place when the humidex reading was 29 or greater, on each occurrence, that the documentation was not consistently completed as required on the log.

The procedure, Hot Weather Related Illness, was not complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure that policies and procedures included in the required Dietary Service and Hydration Program were complied with.

In accordance with Long-Term Care Homes Act (LTCHA) s11(1)(b) the licensee was to ensure that there was an organized program of hydration for the home to meet the hydration needs of residents.
O. Reg. 79/10, s. 68(1)(b) required the licensee to have an organized program of hydration and O. Reg. 79/10 s. 68(2) required the licensee to ensure that the program included the development and implementation of policies and procedures related to nutrition care and dietary services and hydration: including the identification of any risks related to nutrition care and dietary services and
hydration; the implementation of interventions to mitigate and manage those risks and a system to monitor and evaluate the fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the policy and procedure Referral to Nutritional Services in PCC (Point Click Care), numbered C-25-05, revised July 2019.

This policy identified that "Registered nursing staff, or interdisciplinary team members, complete section A of the "Referral Nutritional Services" tool under Assessment Section in PCC for nutritionally related concerns as listed on the tool. If the amount of fluids consumed by the resident is below care plan requirement for three days, the night nurse will review the look back report in PCC and compare three day fluid target intake to the resident's fluid requirement as per dietary Care Plan. If fluid intake is below the target, the nurse will check the resident for signs of dehydration and if any noted, will start a dietary referral".

A. Resident #008 was identified, in their plan of care, at nutritional risk since November 2018.
The resident had a goal statement, in their plan of care, to drink at least a specified amount of milliliters (ml) per day.
The plan also included a focus statement that the resident had variable food and fluid intake, not unusual for resident to consume a percentage of meals and drink less than target fluid minimum at times. Dashboard alerts do not require a referral to RD unless food and fluid pattern changes and noted best meal and usual percentages of meals consumed.
A review of the look back report for two months in 2019, identified that the resident did not achieve their fluid goal on 22 days during the identified time period. Of the incidents identified there were three occasions where the resident did not achieve their goal for three consecutive days or greater.
i. A review of the progress notes for three consecutive days in July 2019, did not include an assessment of the resident for signs of dehydration nor was a referral to Nutritional Services noted in PCC during the time period.
ii. A review of the progress notes for four consecutive days in August 2019, did not include an assessment of the resident for signs of dehydration nor was a referral to Nutritional Services noted in PCC.
An "alert note" dated during the time period, identified that the resident ate less than an identified percentage of intake for three meals within two days, and that the dietitian was aware.
The RD completed a Nutrition and Hydration Risk Assessment on the resident, during the time period which confirmed the risk status and noted that the resident's intake continued to be varied.
iii. A review of the progress notes for three consecutive days in August 2019, did not include an assessment of the resident for signs of dehydration nor was a referral to Nutritional Services noted in PCC.
An "alert note" dated during the time period, identified less than a specified percentage

of intake for three meals within two days, RD aware and following.
Interview with the DOC and RN #115, following a review of the clinical record, confirmed that staff did not follow the policy Referral to Nutritional Services in PCC on the three identified occasions.
Interview with the RD confirmed that, despite the statement in the plan of care regarding poor food and fluid intake, when the resident did not achieve their fluid target for three days in a row a referral should have been sent to Nutrition Services.

B. Resident #010 was identified, at nutrition risk, based on their Nutrition/Hydration Risk Assessment completed in May 2019, and identified at a different nutrition risk, based on their assessment completed in August 2019.
The resident had an intervention in their plan of care, for a beverage target minimum of at least a specified amount of ml per day.
A review of the look back reports from a specified date in June 2019 until another specified date in August 2019 and then again from a specified date in October 2019 until a specified date in November 2019, identified that the resident did not achieve their fluid goal on approximately 25 days, while they were in the home during the identified time period. Of the incidents identified there were two occasions where the resident did not achieve their goal for three consecutive days or greater.
i. A review of the clinical record for nine consecutive days in June 2019, was completed and included a referral to Nutritional Services dated in June 2019, which indicated that the amount of fluids consumed by the resident was below care plan requirement for three days and that the resident did not exhibit any symptoms of dehydration. The RD received and responded to the referral approximately ten days later with an action plan to continue with current care plan.
A review of the progress notes included "alert notes" written by nursing staff for low intake on eight days in June 2019.
The "alert note" dated on a specified date in June 2019, identified "dietary referral sent", followed by notes the next two consecutive days which identified "RD referral previously sent".
ii. A review of the clinical record for eight consecutive days in June 2019 until July 2019, was completed and did not include an assessment of the resident for signs of dehydration nor was a referral to Nutritional Services noted in PCC, despite documentation in the progress notes.
A review of the progress notes included "alert notes" written by nursing staff for low intake on three dates during the time period.
The "alert note" written on an identified date in July 2019, noted that a referral was sent to the dietitian.

An "alert note" written three days later noted that a "referral was sent".
A review of the assessments in PCC identified that, prior to the end of the time period of low fluids, the most recent referral to the RD for low fluid intake was submitted in June 2019, which was responded to by the RD.
Interview with the DOC and RN #115, following a review of the clinical record confirmed that the staff did not follow the policy Referral to Nutritional Services in PCC.
Interview with the RD confirmed that when the resident did not achieve their fluid target for three days in a row a referral should have been sent to Nutrition Services.

Interview with the DOC identified that around the spring/summer of 2019, the home was involved in a pilot project for the licensee, regarding the referral process to the RD, for food and fluid intake of residents. The goal of the pilot was to make the referral process interdisciplinary in nature. The pilot involved team members discussing the resident, their assessment findings and intake at meals prior to submitting a referral to the RD. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system, in place are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under the hydration program, including interventions were documented.

In accordance with LTCHA s.11(1)(b) the licensee was to ensure that there was an organized program of hydration for the home to meet the hydration needs of residents. O. Reg. 79/10, s. 68(1)(b) required the licensee to have an organized program of hydration and O. Reg. 79/10 s. 68(2) required the licensee to ensure that the program included the development and implementation of policies and procedures related to nutrition care and dietary services and hydration and included a system to monitor and evaluate the fluid intake of residents with identified risks related to nutrition and hydration.

Discussion with the DOC, Administrator, Programs Manger and full time PSW #101 and #111 confirmed that specifically during the summer months, the programs department would offer additional fluids to residents in the form of ice cream, popsicles and other special beverages, as an intervention in the Hot Weather Related Illness procedure. The DOC identified that they had recently become aware that these additional fluids were not recorded in the resident specific clinical records as an intervention provided, and their plan to consult with other team members to ensure that all resident fluids were accurately recorded in the clinical health records.
PSW #101 and #111 identified that the home had a process in place for the programs department to communicate, in writing, to nursing staff, residents' intake when they participated in meal programs, outside of the long term care home, and that this information would then be recorded in Point of Care (POC); however, they were not able to recall documenting additional fluids provided by the programs department as a measure carried out in times of heat.
Interview with the Programs Manager confirmed that there was a written system in place to communicate to nursing staff residents' intake at meals when at programs; however, when additional fluids were provided as part of the Hot Weather Related Illness procedure this information, was only verbally communicated to nursing staff.
The program staff did not document fluids consumed in POC.

Not all actions taken with respect to a resident under a program, including interventions were documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a nutrition manager was on site at the home and worked in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

O. Reg. 79/10 s. 75. (4) identified that for the purposes of subsection (3), but subject to subsection (5), the minimum number of hours per week shall be calculated as follows: M = A × 8 ÷ 25 where, "M" is the minimum number of hours per week, and "A" is, (a) if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or (b) if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.

O. Reg. 79/10 s. 75.(5) identified that the Director may take into consideration the hours in a week, if any, devoted to producing meals and other food and beverages for non-residents for the sole purpose of determining, (a) whether the licensee is in compliance with subsection (3); and (b) whether any of the minimum staffing hours under subsection (3) are being devoted to producing meals and other food and beverages for non-

residents.

The Long-Term Care Homes Level-of-Care Per Diem, Occupancy and Acuity-Adjustment Funding Policy, May 2019, identified that: an inspector on behalf of the Director under the LTCHA may apply the following formula to confirm whether the licensee is meeting the minimum requirement set out in section 75 of the Regulation for the nutrition manager(s):
M Total = [A + (B ÷3 ÷ 7) + (C ÷ 3 ÷ 7)] × 8 ÷ 2 where
"M Total" is the minimum number of hours of service per week for the management of all resident and non-resident nutritional care and dietary service programs.
"A" is, if the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week, or if the occupancy of the home is less than 97 per cent, the number of residents residing in the home for the week, including absent residents.
"B" is the total number of meals prepared in the home for the week for persons who are not residents of the home where one or both of the following two conditions are met:
(i) staff are involved in activities in addition to food preparation including but not limited to the following: distribution of meals; receiving, storing and managing of the inventory of food and food service supplies; and daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.
(ii) the menus for residents and persons who are not residents are not the same.
In all cases, the following meals are included under "B": visitors, staff, day care, cafeteria, and catering.
"B" is the sum of meals prepared for each of its components, e.g., meals for visitors, staff, day care, and cafeteria.
As such, "B" is calculated using the following formula:
B=Sbin=i
Where possible each component, i.e.b_ib_i, should be measured using the number of meals prepared. For all operations that generate revenue, such as a cafeteria, the following formula should be applied to calculate b_ib_i:
b= Average weekly revenue i Average cost per meal, where Average cost per meal = Raw food per diem 3
"C" is the total number of meals prepared in the home for other operations where both of the following two conditions are met:
i) LTC staff is only involved in food preparation and not other activities that may include but are not limited to the following: distribution of meals; receiving, storing and managing of the inventory of food and food service supplies; and daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.
ii) the menus for residents and for persons who are not residents are the same.

Interview with the Nutrition Manager (known as FSS) identified that they worked 30 hours a week, in the combined role of FSS and Maintenance Supervisor. They identified that the kitchen also prepared meals for the clients in the attached retirement home.
Interview with the Administrator identified that the long-term care home had achieved their target occupancy of 97% and that the retirement home had the potential capacity of 40 clients; however, occupancy, year to date was approximately 34 clients.
The Administrator confirmed that staff conducted other activities, in addition to food preparation for the retirement clients, who were served the same menu as residents' in the long-term care home.
According to the formula set out in the Long-Term Care Homes Level-of-Care Per Diem, Occupancy and Acuity-Adjustment Funding Policy the FSS was required to be on site and working in the capacity of FSS for a minimum of 30.08 hours a week.
The Administrator confirmed that the allotted time for the FSS to conduct their duties and responsibilities for the maintenance department was five (5) hours a week.
The FSS, responsible for the, long-term care home, nutrition and hydration program, to manage the provision of meals to retirement home clients and as supervisor of the maintenance department shall be onsite for 35.08 hours per week based on the formula calculations and information provided by the Administrator.

The nutrition manager was not on site in the home and working in the capacity of nutrition manager for 30.08 hours per week, without including any hours spent fulfilling other responsibilities. [s. 75. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a nutrition manager is on site at the home and works in the capacity of nutrition manager for the minimum number of hours per week, without including any hours spent fulfilling other responsibilities, to be implemented voluntarily.

Issued on this 21st day of November, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.